Alaska Medicaid Prior Authorization Request Form

Synagis

for RSV Season November 25, 2013 through May 11, 2014

PRESCRIBER USE ONLY**

MAGELLAN MEDICAID ADMINISTRATION

Fax this request to: (888) 603-7696 **Questions?** Call Magellan Medicaid Administration at (800) 331-4475

Or mail this request to: Medicaid PA Unit, 14100 Magellan Plaza, Maryland Heights, MO 63043

REQUESTOR	Must be requested by prescriber. See below.	
RECIPIENT	Last Name, First Name, Middle I.:	
DOB:	Medicaid ID:	Sex: ☐ Male ☐ Female
PRESCRIBER	Name:	NPI: - - - - - - - - - -
Phone: ( )		Fax: ( )
REQUEST	Synagis 50mg NDC 60574411401 QTY -	Requested Start Date / /
	Synagis 100mg NDC 60574411301 QTY -	Requested Start Date / /
	Calculated Initial Dose:	

***** All sections must be completed or the request will not be approved*****

RATIONALE FOR PRIOR AUTHORIZATION

http://dhss.alaska.gov/dhcs/Pages/pharmacy/medpriorauthoriz.aspx

Gestational Age: _____Weeks_____Days *Note: Weeks and days are both required* **Weight in kilograms** _____

☐ **Diagnosis of Chronic Lung Disease** (formerly called bronchopulmonary dysplasia) **AND** child must be < 24 months of age at onset of season on Nov. 25 (DOB after 11/25/11) **AND** child has required medical treatment in the preceding 6 months.
Check/Complete all that apply:
☐Oxygen most recent date administered: _____ ☐Corticosteroids most recent date administered: _____
☐Bronchodilators most recent date administered: _____ ☐Other - most recent date administered: _____
The infant may be approved for no more than 6 monthly doses of palivizumab

☐ **Hemodynamically significant cyanotic or acyanotic Congenital Heart Disease (CHD) AND** child must be < 24 months of age at onset of season on November 25 (DOB on or after 11/25/11).
The infant may be approved for no more than 6 monthly doses of palivizuma.
If the child undergoes cardio-pulmonary bypass surgery during the RSV season, an extra post-operative dose can be authorized.
☐Cardio-pulmonary bypass surgery; Date: _____

☐**Child is ≤ 12 months of age on November 25** (DOB after 11/25/12) **AND**
☐Gestational age ≤ 28 weeks, 6 days,
OR
☐**Child is ≤ 12 months of age on November 25** (DOB after 11/25/12) **AND** diagnosed with:
☐Congenital abnormalities of the airway **OR** ☐Neuromuscular condition requiring handling of respiratory secretions
The infant may be approved for no more than 6 monthly doses of palivizumab

☐**Child is ≤ 6 months of age on Nov. 25 (**DOB after 5/25/13) **AND** gestational age is 29 weeks, 0 days through 31 weeks, 6 days.
The infant may be approved for no more than 6 monthly doses of palivizumab

☐**Child is ≤ 3 months of age on Nov. 25** (DOB on 8/25/13 or after) **AND** gestational age is 32 weeks, 0 days through 34 weeks, 6 days*, **AND:**
☐Child attends daycare, **OR**
☐Child resides in a home with another child < 5 years of age **OR**
☐Child resides in a crowded living environment (≥ 3 children per bedroom or ≥ 7 people per household) **OR**
☐Child resides in a home with lack of running water
*The infant in this category will qualify for monthly doses **only** up until 3 months (90 days) of age.*

Prescriber's Signature	Date